STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00123446. Complaint IN00123446 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F309. Survey dates: February 11, 12 and 13, 2013 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 91 Total: 91 Census payor type: Medicare: 11 Medicaid: 66 Other: 14 Total: 91 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Please find the enclosed plan of correction for the survey ending February 13, 2013. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding,please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review 2/15/13 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure timely notification to the physician and family of a resident's behaviors which included, but were not limited to,	F0157	1. Resident A family and physician notified of refusals. 2. All other residents have the potential to be affected. MARs were reviewed by DNS/designee to identify any resident refusals	02/27/2013

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	refusal of medications for three or more days in a row, for 1 of 3 residents reviewed for physician notification in a sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 2-11-13 at 3:34 p.m. His diagnoses included, but were not limited to, dementia with behavioral disturbances, paranoid schizophrenia, hallucinations, anxiety, coronary artery disease and congestive heart failure. The most recent Minimum Data Set assessment, a significant change MDS, dated 1-30-13, indicated Resident #A had severe cognitive impairment, delusions and worsening behaviors. Review of the Medication Administration Record (MAR) and the nursing notes indicated the resident refused to take medications (meds) on the following dates and times: 1-18-13 and 1-25-13, all morning meds, 1-29-13, all evening meds, 1-30-13, all morning meds, except Depakote; 1-31-13, all morning and afternoon meds, 2-5-13, all morning and afternoon meds, 2-6-13, all morning meds, except Depakote, and all afternoon meds, 2-7-13, all		for three days. No other issues noted. 3. SDC in-serviced licensed nursing staff on Resident Refusal of Medication, Treatments Policy and Procedures (See Attachment A) by 2-26-13. DNS or designee will review MARs and TARs daily and contact doctor and responsible party if medications and/or treatments are refused for three consecutive days. 4. DNS or designee will complete a MAR/TAR Audit for Resident Refusal Audit (See Attachment B) 5 times a week times 2 weeks for all MARs/TARs then 3 times a week times 2 weeks, then weekly times 2 months, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

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	morning and afternoon meds, 2-10-13, all morning, afternoon and evening meds, 2-11-13, all morning and afternoon meds and 2-12-13, all morning meds. The following medications were physician ordered for this resident: aspirin 81 milligrams (mg) every other day by mouth at 8:00 a.m. (indicated as on hold from 1-28-13 to 2-10-13, but not ordered in this manner on 1-28-12); Cerovite Senior (vitamin) daily by mouth at 8:00 a.m.; Aricept 10 mg daily by mouth at 8:00 p.m.; Synthroid 100 micrograms daily by mouth at 8:00 p.m.; Namenda 10 twice daily by mouth at 8:00 a.m. and 4:00 p.m.; Plavix 75 mg daily by mouth at 8:00 a.m. (physician ordered to be on hold 1-28-13, but not indicated in the MAR in this manner); Zocor 40 mg daily vat 8:00 p.m.; Flomax 0.4 mg daily by mouth at 8:00 a.m.; Travatan Z 0.004% solution 1 drop in affected eye once daily at 8:00 a.m.; Ambien 5 mg daily by mouth at 8:00 p.m. (discontinued on 2-6-13); Depakote 250 mg twice daily by mouth at 8:00 a.m. and 8:00 p.m. until 1-29-13 when this medication was increased to three times daily by mouth at 8:00 a.m., 2:00 p.m. and 8:00 p.m.; Vitamin E 400 IU, 4 capsules, daily by mouth at 8:00 a.m.;			

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	Fanapt 6 mg twice daily by mouth at 8:00 a.m. and 8:00 p.m.; Risperdal Consta 25 mg IM (injectable) once every 2 weeks at 8:00 a.m., beginning on 2-12-13. Review of the nursing notes indicated the attending physician and the resident's legal guardian were not notified of the resident's refusal to take his medications during the above time frames, 1-18-13 through 2-11-13. A note written by the Memory Care Unit facilitator on 2-11-13 indicated she had notified the resident's psychiatric care provider and power of attorney of the medication refusals. In interview with the Director of Nursing on 2-13-13 at 8:48 a.m., she indicated Resident #A's attending physician had been to visit the resident the evening before on 2-12-13. She indicated he had written an addendum to his request from 1-28-13 to continue the Plavix, but stop the aspirin for 1 week. She indicated, "I don't think the doctor or the nurse wrote down anything about the resident refusing all or most of his medications for several days in a row, but the doctor was made aware of it. But I know if it isn't charted, it doesn't count." The Administrator provided a copy of			

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	a policy entitled, "Resident Refusal of Medications, Treatments (sic)," on 2-13-13 at 8:55 a.m. This policy was identified as the current policy and had a revision date of 3-10. This policy indicated, "If a resident refuses administration of a medication or treatment for three (3) consecutive days, the physician and family will be contacted and made aware of the refusals." This federal tag relates to complaint IN00123446. 3.1-5(a)(2)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were carried out for timeliness of X-rays after a resident's fall, and medication orders to hold an anticoagulant were documented correctly and administered correctly, for 2 of 3 residents reviewed for physician orders in a sample of 3. (Residents #A and #B) Findings include: 1. Resident #B's clinical record was reviewed on 2-11-13 at 2:52 p.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbances, depression, high blood pressure, chronic obstructive pulmonary disease and advanced age. Review of the nursing notes indicated on 1-27-13 at 2:02 p.m., the resident was being assisted with toileting by a facility CNA when the resident arose very quickly, lost her balance and fell into a shower stall, which resulted in a small laceration to the top right side of	F0282	1. Resident A's physician and family have been notified of the error with medications. Nurse responsible has been terminated. The nurse responsible for not processing Resident B's physician order has also been terminated. IDT met with family on 2-19-13 and discussed the issue. Family satisfied with outcome of the meeting. 2. All residents have the potential to be affected. Medical record audit completed by DNS/designee for all residents to ensure all resident medication and or procedure orders were implemented timely. 3. SDC in-serviced licensed nursing staff on Documentation Guidelines for Nursing Policy and Procedures (See Attachment C), 24 Hour Condition Report Policy and Procedures (See Attachment D), and Pharmakon Policy and Procedures for Ordering Drugs/Biologicals and Medication Order Changes (See Attachment E) on 2-26-13. Licensed nurses will review 24 hour condition report between shifts. DNS or designee will review 24 hour condition report during clinical meeting to verify that physician and responsible party are notified in the documentation and that	02/27/2013

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	her head. The initial assessment of the resident by the licensed nurse indicated no complaints of pain. Nursing notes later that evening at 9:02 p.m. indicated Resident #B complained of back pain, with the physician being notified of the pain. The physician at that time ordered X-rays of the upper and lower back, right ribs and right hip to be conducted at the local hospital. Nursing notes indicated when the resident's power of attorney (POA) was notified of the new orders for X-rays, the POA "requests that X-ray [be] obtained in the morning, or if she wakes in the night [and] c/o [complains of] pain [to send out at that time]." Documentation indicated the resident did not complain of pain during the night. Nursing notes on 1-28-13 indicated the resident was not sent to the local hospital to obtain the X-rays until 3:45 p.m. Nursing notes indicated X-ray results were received the same evening at 6:40 p.m. which indicated non-displaced fractures of the right 7th and 8th ribs, as well as a possible pelvic fracture with recommendations to have further radiological testing to determine if a pelvic fracture was present. Subsequent testing indicated no pelvic fracture.		physician's orders are processed in a timely manner. 4. DNS or designee will complete a Physician's Order Monitoring Audit (See Attachment F) 5 times weekly times 2 weeks on all physician's orders, then 3 times weekly times 2 weeks, then weekly times 2 months, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

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	In interview with LPN #1 on 2-11-13 at 4:40 p.m., she indicated when she arrived on duty on 1-28-13 at 2:00 p.m., she was informed by LPN #2, whom she was relieving, that Resident #B had a physician order for X-rays to be conducted only if the resident complained of pain as a result of a fall the previous day. She indicated upon assessment of the resident and finding her in pain and with bruising at this time, "I told [name of LPN #2] that I was going to send her out [for the X-rays]." She indicated around this time, "The family brought the [ISDH] surveyors back [to the nursing unit]." She indicated the Director of Nursing (DON) "told the surveyors she found the order upside down and under the phone at the nurse's station." Nursing notes indicated LPN #1 notified the physician and received another order on 1-28-13 at 3:13 p.m. to send the resident for X-rays of the lumbar, thoracic and sacral spine, the right ribs and right hip. In interview with LPN #2 on 2-12-13 at 11:40 a.m., she indicated when she arrived on duty on 1-28-13 for the day shift, she received a verbal report from the third shift nurse. She indicated, "I was told to send her over			

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	[to the local hospital] for X-rays if she had pain. Later, I found the actual order under the telephone that said she was to be sent for X-rays...If I would have known she was to go, she would have been sent that morning. The order didn't get processed like it should have been." LPN #2 indicated when she receives a new physician order, she normally would, "Document it in the progress notes and it gets put in the telephone order file." She indicated the "telephone order file" then is taken to the facility's morning meeting to be reviewed by the administrative team, and then is placed in a file for the physician to sign. She indicated she had conducted two pain assessments on the residents that date which were negative. She indicated three different family members were with the resident during these assessments, but they did not address any issues with X-rays at that time. Documentation, dated 1-28-13, provided by the Director of Nursing on 2-12-13 at 4:35 p.m. indicated, "1:30 pm made aware of order on [name of] unit received after fall to send resident for xrays that was not appropriately processed. When found by dayshift nurse, order			

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	immediately processed and resident sent for xrays. Results showed rib fractures post fall. 1-28-2013 @ 4pm: Spoke with nurse who received the order. Stated she told the third shift nurse about the order, but didn't process [the physician order] because she was not sending her out [at that time for the xrays]. 1-28-13 @ 5:45 pm: Spoke with the third shift nurse who stated she thought order was processed and res[ident] had no pain." 2. Resident #A's clinical record was reviewed on 2-11-13 at 3:34 p.m. His diagnoses included, but were not limited to, dementia with behavioral disturbances, paranoid schizophrenia, hallucinations, anxiety, TIAs (transient ischemic attacks or small strokes), coronary artery disease and congestive heart failure. The most recent Minimum Data Set assessment, a significant change MDS, dated 1-30-13, indicated Resident #A had severe cognitive impairment, delusions and worsening behaviors. Review of a physician's progress note, dated 1-28-13, indicated, "Hold Plavix for few [unclear penmanship, unable to determine time frame]." Review of the Medication			

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	Administration Record (MAR) indicated to hold the aspirin 81 milligrams (mg) from 1-28-13 through 2-10-13. The MAR did not indicate any "hold" information for the Plavix 75 mg on the January or February, 2013 MAR, as of 2-12-13. The MAR did indicate Resident #B did refuse to take the Plavix on 1-30-13, 1-31-13, and February 5 through 12, 2013. He did accept the Plavix on February 1 through 4, 2013. An addendum, dated 2-12-13, was documented on a physician's progress note which indicated, "Continue Plavix [secondary to] rec [recommended for] TIA. D/C [discontinue] ASA [aspirin] for 1 week." Review of the nursing notes indicated the attending physician nor the resident's legal guardian were notified of the error with these medications. In interview with the Director of Nursing on 2-13-13 at 8:48 a.m., she indicated Resident #A's attending physician had been to visit the resident the evening before on 2-12-13. She indicated he had written an addendum to his request from 1-28-13 to continue the Plavix, but stop the aspirin for 1 week. This federal tag relates to complaint IN00123446.			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure physician-ordered X-rays, after a resident's fall which resulted in two fractured ribs, were obtained in a timely manner for 1 of 3 residents reviewed for falls in a sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 2-11-13 at 2:52 p.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbances, depression, high blood pressure, chronic obstructive pulmonary disease and advanced age. Review of the nursing notes indicated on 1-27-13 at 2:02 p.m., the resident was being assisted with toileting by a facility CNA when the resident arose very quickly, lost her balance and fell into a shower stall, which resulted in a small laceration to the top right side of	F0309	1. The nurse responsible for not processing Resident B's physician order was terminated. IDT met with family on 2-19-13 and discussed the issue. Family satisfied with outcome of the meeting. 2. All residents have the potential to be affected. Medical record audit completed by DNS/designee for all residents to ensure all resident medications and/or procedures were implemented timely. 3. SDC in-serviced licensed nursing staff on Documentation Guidelines for Nursing Policy and Procedures (See Attachment C), 24 Hour Condition Report Policy and Procedures(See Attachment D), and Pharmakon Policy and Procedures for Ordering Drugs/Biologicals and Medication Order Changes (See Attachment E) on 2-26-13. Licensed nurses will review 24 hour condition report between shifts. DNS or designee will review 24 hour condition report during clinical meeting to verify that physician and responsible party are notified in the documentation and that physician's orders are processed	02/27/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her head. The initial assessment of the resident by the licensed nurse indicated no complaints of pain. Nursing notes later that evening at 9:02 p.m. indicated Resident #B complained of back pain, with the physician being notified of the pain. The physician at that time ordered X-rays of the upper and lower back, right ribs and right hip to be conducted at the local hospital. Nursing notes indicated when the resident's power of attorney (POA) was notified of the new orders for X-rays, the POA "requests that X-ray [be] obtained in the morning, or if she wakes in the night [and] c/o [complains of] pain [to send out at that time]." Documentation indicated the resident did not complain of pain during the night. Nursing notes on 1-28-13 indicated the resident was not sent to the local hospital to obtain the X-rays until 3:45 p.m. Nursing notes indicated X-ray results were received the same evening at 6:40 p.m. which indicated non-displaced fractures of the right 7th and 8th ribs, as well as a possible pelvic fracture with recommendations to have further radiological testing to determine if a pelvic fracture was present. Subsequent testing indicated no pelvic fracture.		in a timely manner. 4. DNS or designee will complete a Physician's Order Monitoring Audit (See Attachment F) 5 times weekly times 2 weeks on all physician's orders, then 3 times weekly times 2 weeks, then weekly times 2 months, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	02/13/2013

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	In interview with LPN #1 on 2-11-13 at 4:40 p.m., she indicated when she arrived on duty on 1-28-13 at 2:00 p.m., she was informed by LPN #2, whom she was relieving, that Resident #B had a physician order for X-rays to be conducted only if the resident complained of pain as a result of a fall the previous day. She indicated upon assessment of the resident and finding her in pain and with bruising at this time, "I told [name of LPN #2] that I was going to send her out [for the X-rays]." She indicated around this time, "The family brought the [ISDH] surveyors back [to the nursing unit]." She indicated the Director of Nursing (DON) "told the surveyors she found the order upside down and under the phone at the nurse's station." Nursing notes indicated LPN #1 notified the physician and received another order on 1-28-13 at 3:13 p.m. to send the resident for X-rays of the lumbar, thoracic and sacral spine, the right ribs and right hip. In interview with LPN #2 on 2-12-13 at 11:40 a.m., she indicated when she arrived on duty on 1-28-13 for the day shift, she received a verbal report from the third shift nurse. She indicated, "I was told to send her over			

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	[to the local hospital] for X-rays if she had pain. Later, I found the actual order under the telephone that said she was to be sent for X-rays...If I would have known she was to go, she would have been sent that morning. The order didn't get processed like it should have been." LPN #2 indicated when she receives a new physician order, she normally would, "Document it in the progress notes and it gets put in the telephone order file." She indicated the "telephone order file" then is taken to the facility's morning meeting to be reviewed by the administrative team, and then is placed in a file for the physician to sign. She indicated she had conducted two pain assessments on the residents that date which were negative. She indicated three different family members were with the resident during these assessments, but they did not address any issues with X-rays at that time. Documentation, dated 1-28-13, provided by the Director of Nursing on 2-12-13 at 4:35 p.m. indicated, "1:30 pm made aware of order on [name of] unit received after fall to send resident for xrays that was not appropriately processed. When found by dayshift nurse, order			

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	immediately processed and resident sent for xrays. Results showed rib fractures post fall. 1-28-2013 @ 4pm: Spoke with nurse who received the order. Stated she told the third shift nurse about the order, but didn't process [the physician order] because she was not sending her out [at that time for the xrays]. 1-28-13 @ 5:45 pm: Spoke with the third shift nurse who stated she thought order was processed and res[ident] had no pain." This federal tag relates to complaint IN00123446. 3.1-37(a)			